ii. Preface

In 1993, the Maryland General Assembly enacted health care reform legislation that had the creation of the Maryland Medical Care Data Base as one of its most important elements. At the core of the legislation's intent was a belief that information should be used to encourage competition in order to lower cost and improve quality. The Maryland Legislature envisioned information that would support the development of cost containment strategies as well as assist consumers, practitioners, payers, and policymakers in health care decision-making.

For the past four years, the Maryland Health Care Commission (MHCC) has collected health care resource and expenditure data. The first two years of data collection were on a voluntary basis and the last two years through regulations on all major insurance companies and health maintenance organizations (HMOs). The first three reports combined information on aggregate health resources and expenditures for the state, as well as more specific information on the services provided by health care practitioners in the ***"Annual Report on Expenditures and Utilization."*** Last year the ***"Annual Report on Expenditures and Utilization"*** was divided into two separate reports, and that same format is being followed this year. In January, the MHCC released its report on state health care resources and aggregate expenditures titled, "***State Health Care Expenditures: Experience from 1998."***

"Practitioner Expenditures and Utilization: Experience from 1998" presents analyses of the services provided by physicians and other non-physician health practitioners. MHCC has devoted an entire report to practitioner services because these services accounted for over 36 percent of Maryland's total health care expenditures in 1998, an increase of 6.6 percent from 1997 spending. The information in this report is derived from analyses using the 1998 Medical Care Data Base which contains information on the health care practitioner services provided to Maryland residents. Insurance companies and HMOs submit this information to the Commission under the requirements of COMAR 10.25.06.

Purpose of the Report

This report meets the requirements under Health-General Article, §19-1502(c)(7) which directs the Commission to report on statewide variations in fees and utilization of services provided by health care practitioners and office facilities. With the exception of Medicaid data in 1998, this is the third year that the detailed procedure-level and diagnosis-level analyses are based on data submitted by all major payers. Consequently, this report provides benchmarks and detailed information for comparing current activities. Although this is an important milestone, the MHCC recognizes that this advancement is just one of many in the long-term process of making information on expenditures and utilization available to policymakers.

Organization of the Report

This report is presented in six chapters.

- **Chapter 1** describes the methods and assumptions that the Commission used in conducting research for the report. This chapter discusses data limitations that are significant for interpreting results from subsequent chapters and concludes with a discussion of the progress that HMOs have made in submitting information on capitated services.

- **Chapter 2** presents a comprehensive analysis of practitioner utilization and expenditures by the age of patient and payer status. For this year's analysis, MHCC will compare utilization and expenditures across four broad delivery system types:

  - **Private non-HMO** consists of services provided through traditional private health insurance including indemnity and preferred provider products.

  - **Private HMO fee-for-service (FFS**) includes services provided to HMO members by practitioners who bill the HMO for their services (i.e., not capitated).

  - **Medicare non-HMO** consists of services provided to beneficiaries through the traditional Medicare indemnity program.

  - **Medicare HMO FFS** includes practitioner services provided to Medicare certified HMO members by practitioners who bill the HMO for their services (i.e., not capitated).

  In this and the subsequent three chapters, utilization under each of these broad payer delivery systems is studied on various dimensions. In Chapter 2, utilization is examined in further detail by urban and rural status and by the main clinical conditions for which the patient sought care.

- **Chapter 3** provides a more detailed analysis of utilization by practitioner specialty. The chapter begins with an examination of physician supply statewide and for the five regions of the state.[1] The remaining sections of this chapter examine utilization of specific specialties by patients.

- **Chapter 4** examines utilization by type of service categories and by high utilization procedure codes. The broad categories developed from the Berenson-Eggers Type of Service methodology support the examination of all services in clinically meaningful

[1] The five regions of Maryland are: National Capital Area, Baltimore Metro Area, Eastern Shore, Southern Maryland, and Western Maryland.

categories.[2] MHCC also presents the highest-ranking services by delivery system as required by law.

- **Chapter 5** centers on geographic variations in the use of services. The chapter provides a detailed examination of utilization by practitioner specialty and region. In and out-of-state migration to obtain practitioner services is examined in detail.

- **Chapter 6** presents the Commission's first effort to analyze capitated services alone and in conjunction with the HMO FFS services discussed in Chapters 2 though 5. The chapter contains discussions on the level, distribution, and character of capitated services. Specifically, within HMOs, the number of capitated services and their associated work RVUs (relative value units) are contrasted with the HMO FFS experience. Although this is a modest step forward, the effort continues the Commission's initiative to understand and describe the types of services provided through capitated reimbursement.

[2] Information on the Berenson-Eggers Type of Service system is available from the Health Care Financing Administration at http://www.hcfa.gov/stats/btoscrst.htm.